Maryland's Comprehensive HIV Prevention Plan 2004-2008

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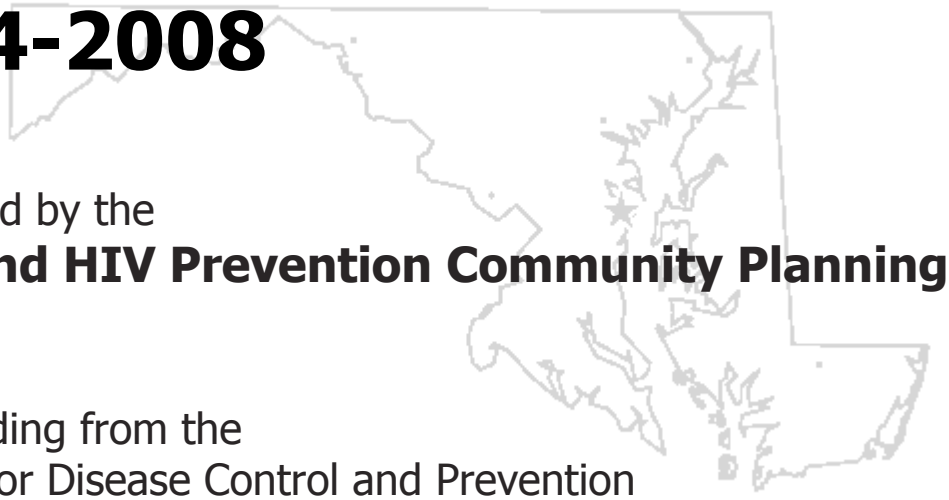

Developed by the
Maryland HIV Prevention Community Planning Group

With funding from the
Centers for Disease Control and Prevention

In Partnership with the
AIDS Administration
Department of Health and Mental Hygiene
State of Maryland

June 2007

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INTRODUCTION

Since its inception in 1994, HIV prevention community planning in Maryland has emphasized an inclusive process of community participation, data collection, and rational analysis. Representatives from different geographic regions and from various infected and affected groups across Maryland meet on an ongoing basis to consider the nature and extent of the HIV/AIDS epidemic and prevention programs needed to stem the epidemic's spread. The steps in the process include identifying risk groups, collecting data from members of these groups and others, assessing needs, reviewing epidemiological and behavioral science information, and developing and ranking priorities for prevention programming.

In order to strengthen community participation, planning leaders pay a good deal of attention to training and orientation to planning tasks, team building exercises, an annual retreat, and regular educational and informational presentations.

SECTION ONE:
Important Questions and Answers

What is HIV Prevention Community Planning?

HIV Prevention Community Planning is a collaborative planning process that brings people together to plan and monitor HIV prevention efforts in their communities. Via the CPG, health departments and the community work to prevent the spread of HIV infection as well as support those who have been infected and impacted by HIV and AIDS.

How is Community Planning Organized in Maryland?

The central vehicle for prevention planning in Maryland is the Community Planning Group (CPG). The CPG is governed by a Charter that it developed and modified as necessary over time (see Appendix A). It is co-chaired by a community representative elected by the CPG members and the Planning Manager from the State AIDS Administration. The CPG has up to 30 voting members drawn from five geographic regions that cover the entire state and represent the groups at risk of contracting or spreading HIV. The socio-demographic representation of the CPG is determined by the characteristics of the epidemic. This demographic profile is subject to change as new members are added and long-term members reach their term limits. (See Section Two for the current CPG composition). A membership committee recommends new members to the Administration to reach representation goals. In addition, the CPG has five non-voting members representing several HIV prevention partner agencies. These include: the Department of Health and Mental Hygiene (DHMH)-Mental Hygiene Administration, the Alcohol and Drug Abuse Administration, the Maryland State Department of Education and the Sexually Transmitted Disease Division.

The CPG accomplishes much of its work through committees. These include the Executive, Membership, Policy, and Program Advisory Committees as well as Regional Work Groups (see below). All of the members of the CPG are involved in at least one working committee. Duties of each committee are as follows:

- A six-member **Executive Committee** is comprised of the Community Chair, the State Health Department Chair and four members from the CPG. The Executive committee considers policies, represents the CPG between meetings and makes recommendations to the CPG.
- The **Community Services Assessment Committee** creates and distributes the Community Services Assessment. They also evaluate the linkages between the HIV Prevention Plan, the Application, and funded programs.
- The **Continuing Education Committee** assesses the educational needs of the CPG members and provides ongoing education to the entire CPG about planning products and activities.
- The **Membership and Recruitment Committee** recruits and screens potential CPG members and recommends their appointment by the Director of the AIDS Administration. The committee's goal is to ensure that the CPG is a body that is inclusive and representative of groups infected and affected by HIV/AIDS in Maryland.
- The **Program Advisory Committee** researches effective methods for reaching target populations and Reviews information on effective interventions. They then advise the AIDS Administration staff on the adaptation of best practices to the specific culture of target populations in the design of prevention programs.
- In addition, five **Regional Work Groups (RWGs)** extend opportunities for participation in the community planning process around the state.

Along with the CPG, the RWGs play a critical role in community planning. In order to make the statewide community planning process more inclusive, in 1995 the CPG established and began to provide staff support for five RWGs representing the Central, Eastern, Southern, Suburban, and Western areas of the state. Membership in the RWGs is open to any interested person in the respective region. The RWGs are linked to the CPG via a co-chair who is also a CPG member.

What is the main purpose of the CPG?

The main purpose of the CPG is to develop a comprehensive HIV Prevention Plan consistent with the high priority prevention needs identified through the HIV Prevention community planning process. It also is responsible for assessing the responsiveness and effectiveness of the Maryland AIDS Administration's Application to the Centers of Disease Control and Prevention (CDC) in addressing the priorities identified in the Comprehensive HIV Prevention Plan. The CPG conducts its business through regular monthly meetings and additional meetings as necessary.

What is a "Comprehensive HIV Prevention Plan"?
A comprehensive HIV prevention plan is a document that summarizes the collaborative work of the CPG and Health Department in a locality. Per CDC instructions, the plan should highlight and describe high priority needs identified through the community planning process. All localities that receive community-planning funds from the Centers for Disease Control and Prevention (CDC) are required to submit a plan. CPGs are also expected to regularly review, revise and refine plans as indicated by new or enhanced surveillance data, intervention research, needs assessment, resource inventory, program policy or technology information.

The Maryland HIV Prevention Plan includes:
(1) Epidemiologic Profile; (2) Community Services Assessment; (3) Strategies and Interventions; (4) Prioritization of Populations and Interventions; (5) Linkages; (6) Goals; (7) Performance Indicators; and (8) Planning Budget.

Who is the Maryland Plan intended for?
The Plan has varied audiences, but is intended as a guide for all HIV prevention work throughout the State of Maryland. In particular, we hope that the following will find this to be a useful tool to help plan for the critical HIV prevention work that is so needed to reduce the incidence of HIV infections among the residents of the state of Maryland:

- Community-Based Organizations and Service Providers
- Local Health Departments
- CDC
- Policymakers
- Faith-Based Organizations
- Private Foundations and
- Other individuals who are affected by or interested in HIV prevention

When and where will I first see evidence of this plan in action?
The plan is in action right now, and it will continue to be in action for as long as DHMH and the CPG work together to prevent HIV infections in Maryland. The AIDS Administration and the CPG see this plan as a dynamic document. The plan will continue to evolve as collaborative initiatives are created and enhanced; as new information becomes available; and as new models, gaps in services and high-risk groups are identified. Currently, HIV prevention programs in the community are guided by the priorities set by CPG.

What behaviors place a person at risk for HIV?
The behaviors that place a person at risk for HIV include unprotected sexual (anal, oral, or vaginal) intercourse without a condom and sharing needles or syringes when shooting substances into the body or when home tattooing and piercing. HIV can also be passed from an HIV-infected mother to her child through childbirth or breastfeeding.

HIV is not transmitted through hugging, kissing, massaging, shaking hands or living in the same house with someone who has HIV.

What is the picture of HIV / AIDS in Maryland and Nationally?
Maryland AIDS cases differ from the national cases in terms of gender, race/ethnicity and mode of exposure. HIV comparisons are not investigated because national HIV surveillance information is incomplete at this time.

Gender
Female AIDS cases comprised a higher percentage of all adult/adolescent cases in Maryland than national cases in 2004 (Maryland 33% female versus national 27% female).

Race/Ethnicity
Compared to national AIDS cases, a higher percentage of Maryland cases are African-American (Maryland 81% versus national 48%), while a much lower percentage are Hispanic (Maryland 3% versus national 21%), and white (Maryland 16% versus national 29%). These racial differences are partly due to the differences between the Maryland population and the U.S. national population. Maryland has a greater percentage of African-Americans than the national percentage (28% versus 12%, respectively). Additionally, Maryland has a very small Hispanic population compared to the United States (4% versus 13%, respectively); therefore, few of Maryland's AIDS cases are Hispanic.

Exposure Category
Maryland AIDS cases are more likely to report injection drug use (Maryland 39% versus national 20%), more likely to report heterosexual contact as their mode of exposure (Maryland 38% versus national 68%), and less likely to report that they are MSM than national cases (Maryland 21% versus national 47%). Cases with risk not specified (RNS) are excluded from these comparisons.

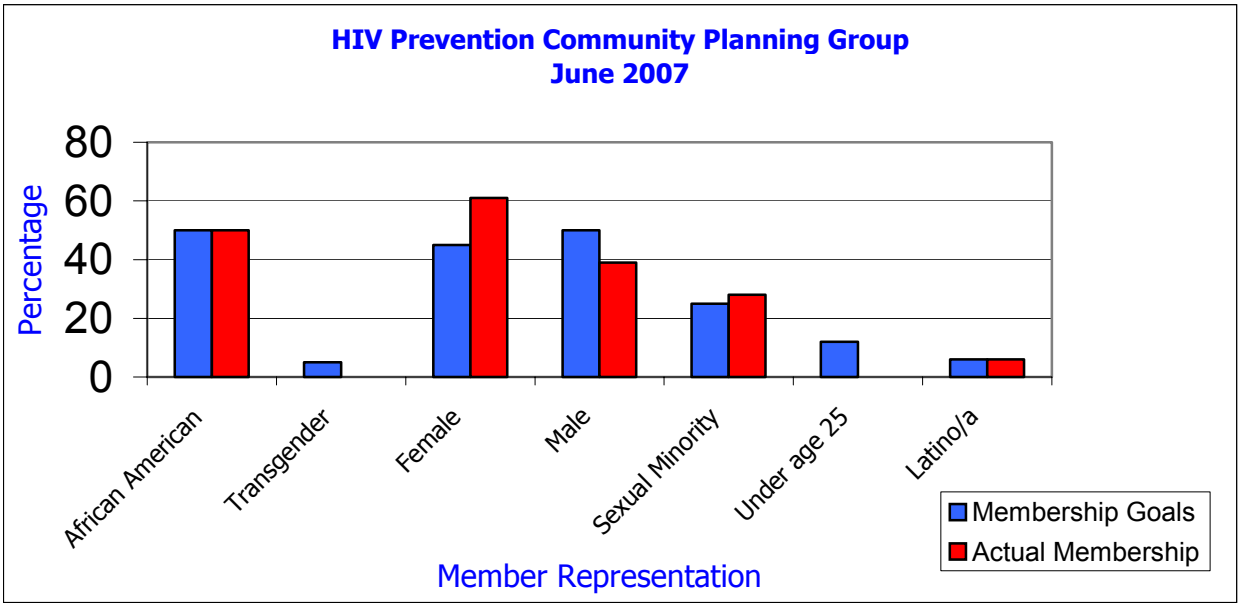
Overview of the HIV/AIDS Epidemic in Maryland
There were 2,121 HIV (non-AIDS) cases and 1,456 AIDS cases diagnosed in Maryland in 2004, as reported through June 30, 2005. Incident HIV (non-AIDS) case measures include individuals who progressed to AIDS within the same calendar year of their HIV diagnosis. Incidence measures are important in determining target populations for prevention programs. The numbers of newly diagnosed HIV and AIDS cases in a given year are used as measures of what is occurring in our epidemic recently. Because there is a lag time between the diagnosis of an HIV or AIDS case and its entry into the HIV and AIDS registries, incidence data from 2004 reported through June 2005 may be understated. Recent annual data are useful for determining which populations are currently affected by HIV/AIDS and to what magnitude. United States Census data from 2000 were used to obtain demographic and geographic distributions of the Maryland population. According to the 2000 Census, Maryland's population has grown 10.8% since 1990, from 4,781,468 to 5,296,486. However, the population of Baltimore City has

undergone an 11.5% decline from 736,014 to 651,154. Most of the county populations have increased, with the exception of Allegany County, which has decreased slightly. African-Americans represent a greater proportion of all Maryland residents in the 2000 Census (27.6%) compared to the 1990 Census (24.9%). Whites represent a smaller proportion of all Maryland residents in the 2000 Census (62.1%) compared to the 1990 Census (71.0%). Comparisons between the Maryland general population and incident HIV and AIDS cases are made to identify populations in which the HIV/AIDS epidemic has had the greatest impact.

SECTION TWO:
Membership Representation on the CPG
Maryland CPG Mission Statement
2006 CPG Planning Year

Membership Representation on the CPG

The purpose of the Community Planning Process is to give the community a chance to tell the state health department about the needs of persons at risk for transmitting HIV. The Community Planning Group (CPG) gives the community a way of communicating with public health officials working on HIV prevention. The CPG is designed to look like the epidemic, based on what we know from the epidemiologic data. For example, the CPG includes African-Americans, people who have used injecting drugs, men who have sex with men, people who have been in prison, and people infected with HIV. The CPG also includes people who provide prevention services to people at risk of transmitting HIV. The process of involving the community in planning improves the state's use of resources. For example, having people who have shared intravenous drugs involved helps us design better programs for injection drug users. Also, having such persons participating helps us avoid designing programs for that population which members of that population know would not work. Additionally, persons living with HIV/AIDS are well represented on the CPG.



Thus, current vacancy priorities for the CPG include Latinos, Transgender individuals, and youth. Additionally, there is a need for more representation from the Suburban Region.

Maryland CPG Mission Statement

The Maryland HIV Prevention Community Planning Group

The mission of the Maryland HIV Prevention Community Planning Group (CPG) is to guide the HIV prevention efforts in Maryland as representatives of communities infected and affected by HIV/AIDS. In order to meet these goals the CPG will focus on the following objectives;

Development of an HIV Prevention Plan

- Identify existing assessments of needs, inclusive of community, academic, and Ryan White products.
- Examine relevance and quality of existing needs assessments.
- Explore alternate methodologies and topics.
- Query the community.
- Demonstrate how identified needs informed priority setting and/or program design/ implementation.
- Conduct a community services assessment to identify gaps in services.
- Ensure the provision and evaluation of effective HIV prevention interventions.
- Advocate for the resources to meet those needs.

Collaboration with Planners and Providers

- Attend coalition meetings.
- Encourage and support local, state and federal partnerships.
- Understand available resources from other sources that support our efforts to improve the health of priority populations.

Policy Making Education

- Invite advocacy groups to present at CPG meetings.
- Report legislative updates at CPG meetings.
- Educate and inform policy makers of the gaps in HIV prevention services.

CPG Member Education

- Provide a thorough orientation to new CPG members. By the end of the orientation CPG members should be familiar with the development of the Maryland HIV Prevention Plan.
- Provide orientation reviews for CPG members throughout the planning year.
- Cultivate leadership through opportunities to serve as CPG Co-Chair, Executive Committee member, and/or Chair of a CPG Committee.

Community Empowerment: Capacity Building of Affected Communities in Community Planning

- The CPG will provide educational presentations to the community. These presentations shall describe the community planning process.
- Build community understanding of the CPG in order to increase participation in planning and prevention.
- Cultivate leadership and expertise in HIV prevention.

2006 CPG Planning Year

In 2005, the Program Advisory Committee expressed an interest in learning about the performance indicators, evaluation data, and interventions utilized in relation to specific priority populations (i.e. HIV Positive Individuals, High Risk Heterosexuals, etc.). The desire for presentations by priority population was echoed by the CPG as a whole. In a response to this, the 2006 CPG agenda was developed around providing a systematic overview of the programs that are used to reach the target populations identified by the CPG. Each target population was the subject of a detailed presentation to the CPG, usually one at each meeting. Each presentation detailed the programs goals, reach, and outcomes. Creation of these presentations brought together program managers, evaluators, and facilitators. In early 2007, the presentations were compiled and bound so that CPG members would have them to reference throughout the year.

In an effort to increase awareness about the CPG in the community, the Executive Committee decided to have a Bring a Friend Day. CPG members were asked to bring guests to the February meeting. A total of 15 community members attended this meeting. The May meeting was held at the AIDS Administration. This allowed CPG members to see the facilities and meet AIDS Administration personnel.

At the CPG Retreat in October a major topic of conversation was the CPG's committees. After reviewing committee setups at some of the other CPGs nationwide, the members voted to alter their committee structure. As a response to members desire for more direction in their role on the CPG, a Continuing Education Committee was added. The Program Advisory Committee was split into two committees: Program Advisory and Community Services Assessment. This will allow each committee to focus more closely on their assigned task. The Membership Committee had Recruitment added to its title to highlight its plan to be more proactive in finding new members. CPG Members were asked to commit to a certain committee for the coming year; effort was also made to balance the number of members on each committee. Emphasis was placed on the importance of having consistent committee meetings during each CPG meeting.

SECTION THREE:
Epidemiologic Profile

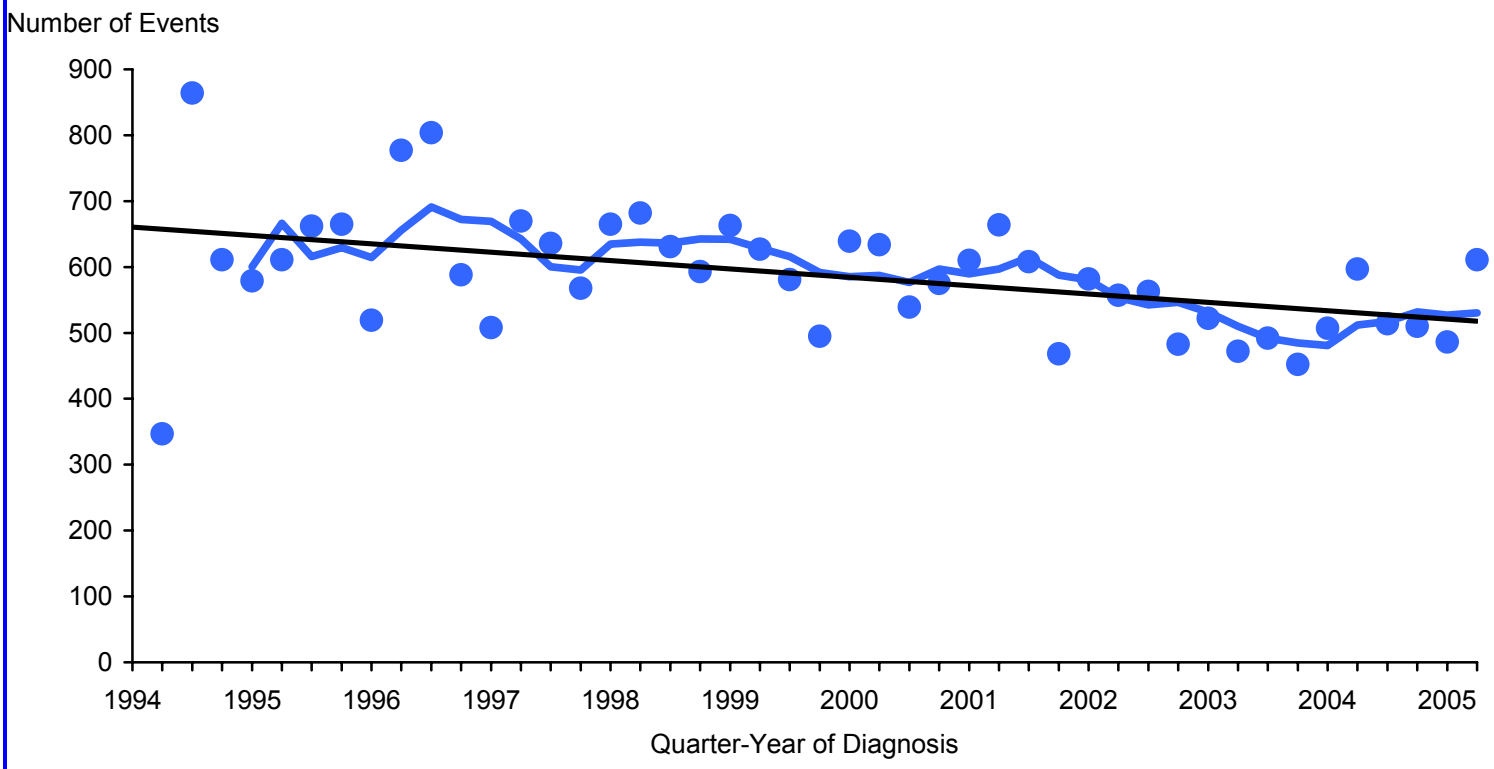
Percent distributions of mode of exposure are based on individuals with risk information available. Individuals with no current information on exposure are labeled risk not specified (RNS) or missing. Exposure information for 2005 incident cases is presented for 54% of the HIV cases and 94% of the AIDS cases. For surveillance purposes, HIV and AIDS cases are counted only once in the following hierarchy of HIV risk: men who have sex with men (**MSM**); injection drug use (**IDU**); hemophilia/coagulation disorder; **heterosexual contact** (with a partner who has or is at risk of HIV); receipt of blood transfusion, blood components, or tissue; other risk, which includes occupational exposures; and risk not specified (RNS). Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy. The exception to this rule is for men who have a history of both sexual contacts with other men and injection drug use; they represent a separate dual exposure category (MSM/IDU).

The proportion of HIV and AIDS cases attributed to **heterosexual contact** has been increasing in Maryland. The CDC defines heterosexual risk as heterosexual contact with someone in a primary risk group (MSM, IDU, hemophiliac) or with someone known to be HIV infected. Therefore, those with AIDS who acquired HIV from heterosexual contact with a person of unknown risk are not categorized by the CDC as heterosexual risk but rather as risk not specified (RNS). Incorporated as a part of Maryland's HIV surveillance system, those who acquired HIV through heterosexual contact are classified into one of two groups: heterosexual contact with a partner at risk (Heterosexual PR) and heterosexual contact with a partner of indeterminate risk (Heterosexual PI), which is classified by the CDC as RNS. Both categories, Heterosexual PR and Heterosexual PI, are employed in this report to show modes of exposure to HIV; Heterosexual PR alone is used to describe modes of exposure for AIDS cases. **Heterosexual contact** was the most common mode of exposure among incident HIV cases (42.9%). **Injection drug use (IDU)** was the mode of exposure in 25.3% of incident HIV cases; **MSM** in 22.5% of incident HIV cases, **MSM/IDU** in 1.7% of incident HIV cases.

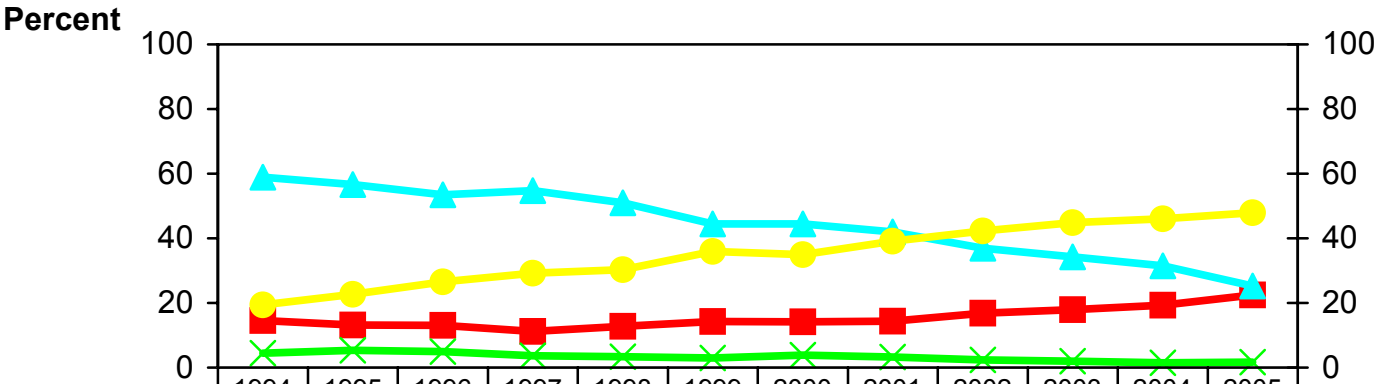
There continues to be a consistent and disproportionate impact on people of color, especially African Americans.

The following pages visually illustrate the trends of transmission by risk behavior in the State of Maryland. This illustration served as the foundation for the priority setting to be discussed in section five of this document.

Maryland HIV Incidence Trends



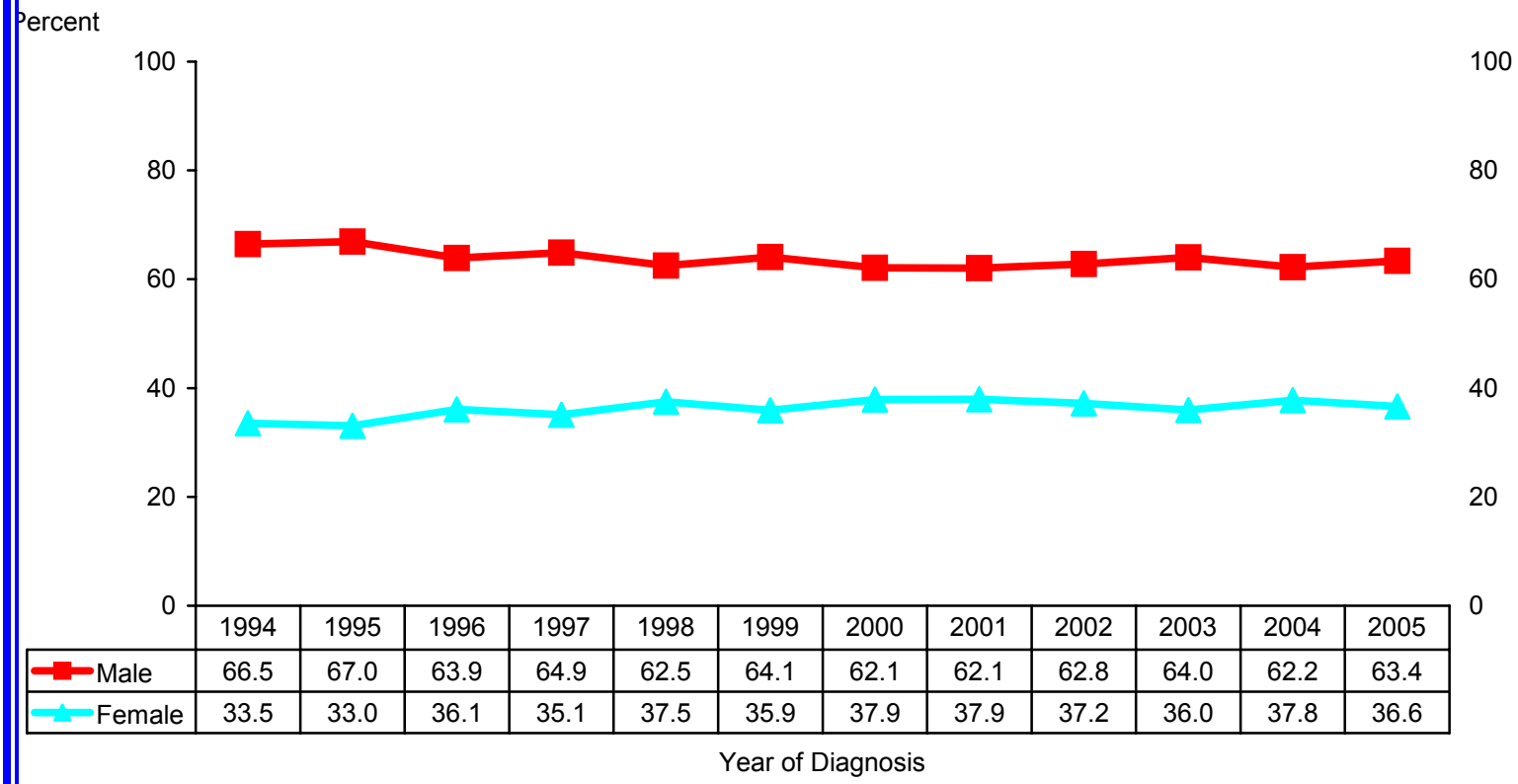
Maryland HIV Incidence by Exposure



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
MSM	14.6	13.2	13.1	11.1	12.8	14.3	14.2	14.3	16.8	17.9	19.3	22.5
IDU	58.9	56.7	53.5	54.8	51.0	44.5	44.5	42.0	37.0	34.3	31.5	25.3
HetSex	19.4	22.7	26.6	29.2	30.3	36.0	34.9	39.1	42.2	44.9	46.1	47.9
MSM/IDU	4.5	5.3	5.0	3.7	3.4	3.0	3.9	3.3	2.4	2.0	1.5	1.7

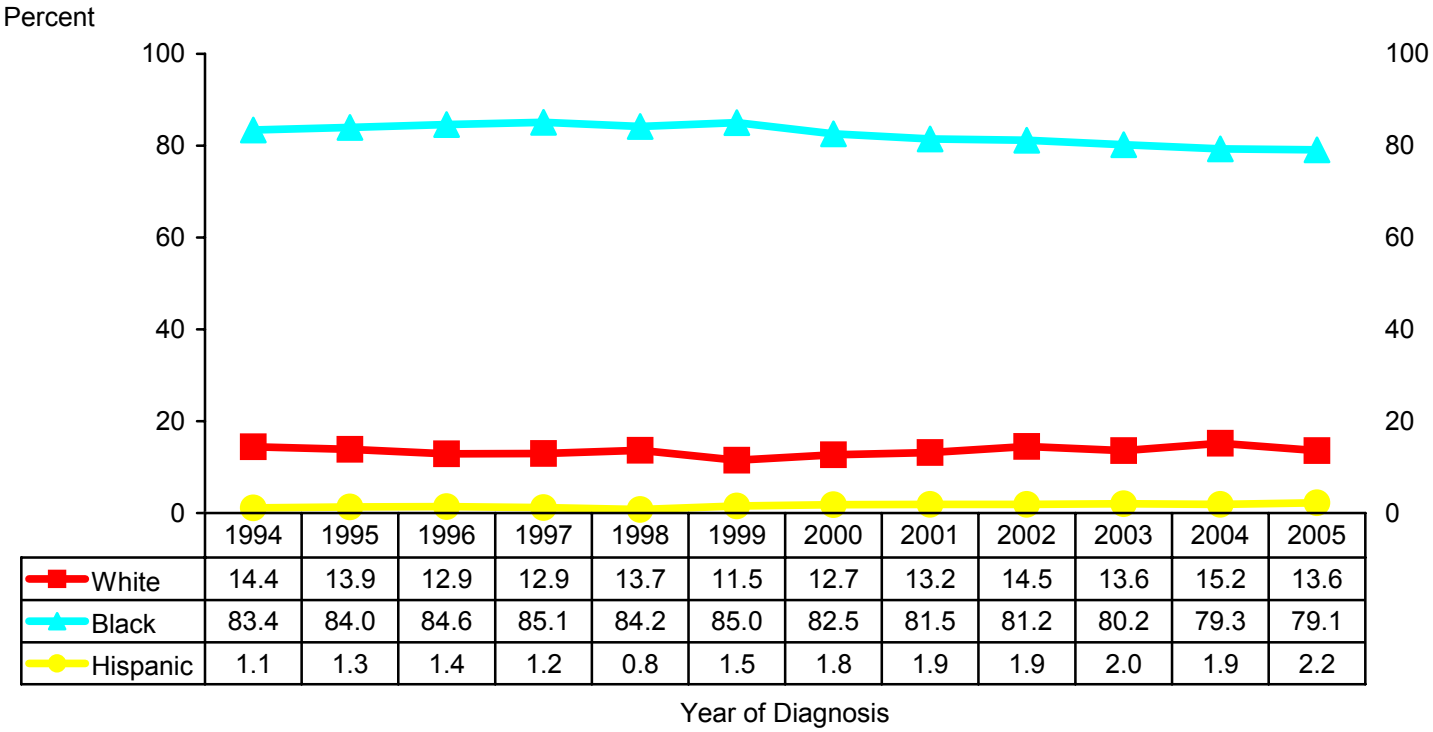
Year of Diagnosis

Maryland HIV Incidence Trends by Gender



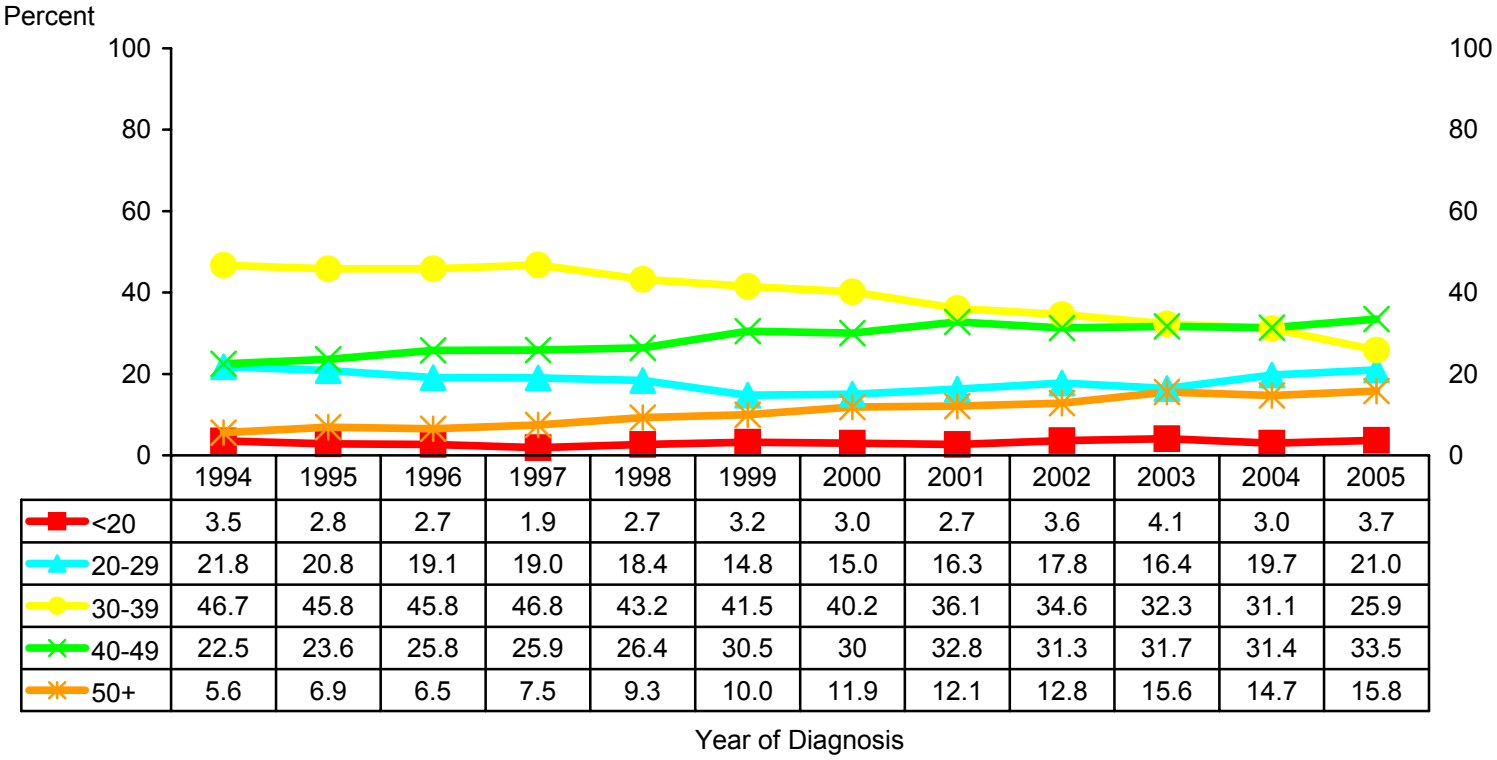
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Male	66.5	67.0	63.9	64.9	62.5	64.1	62.1	62.1	62.8	64.0	62.2	63.4
Female	33.5	33.0	36.1	35.1	37.5	35.9	37.9	37.9	37.2	36.0	37.8	36.6

Maryland HIV Incidence Trends by Race/Ethnicity



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
White	14.4	13.9	12.9	12.9	13.7	11.5	12.7	13.2	14.5	13.6	15.2	13.6
Black	83.4	84.0	84.6	85.1	84.2	85.0	82.5	81.5	81.2	80.2	79.3	79.1
Hispanic	1.1	1.3	1.4	1.2	0.8	1.5	1.8	1.9	1.9	2.0	1.9	2.2

Maryland HIV Incidence Trends by Age Group



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
<20	3.5	2.8	2.7	1.9	2.7	3.2	3.0	2.7	3.6	4.1	3.0	3.7
20-29	21.8	20.8	19.1	19.0	18.4	14.8	15.0	16.3	17.8	16.4	19.7	21.0
30-39	46.7	45.8	45.8	46.8	43.2	41.5	40.2	36.1	34.6	32.3	31.1	25.9
40-49	22.5	23.6	25.8	25.9	26.4	30.5	30	32.8	31.3	31.7	31.4	33.5
50+	5.6	6.9	6.5	7.5	9.3	10.0	11.9	12.1	12.8	15.6	14.7	15.8

SECTION FOUR:
Community Services Assessment

The CDC requires that each CPG include a Community Services Assessment (CSA) as part of their comprehensive HIV prevention plan. The CSA is meant to describe the prevention needs of the populations at risk for HIV, outline the prevention activities and interventions used to address these needs, and analyze of the gaps between needs and services.

There are three components to the Community Services Assessment.

- Resource Inventory (HIV prevention activities)
- Needs Assessment (Determines the scope of the HIV prevention needs)
- Gaps Analysis (Unmet needs)

The CPG Program Advisory Committee represented the CPG as a whole in influencing which data would be included in the 2008 CSA. While previous years had focused on the funding distribution among priority populations, the Program Advisory Committee requested information on which populations implemented prevention programs reached. The following Community Services Assessment examines both budgetary and reach data. These statistics can then be compared to the epidemiological profile to evaluate where some of the gaps in services are located.

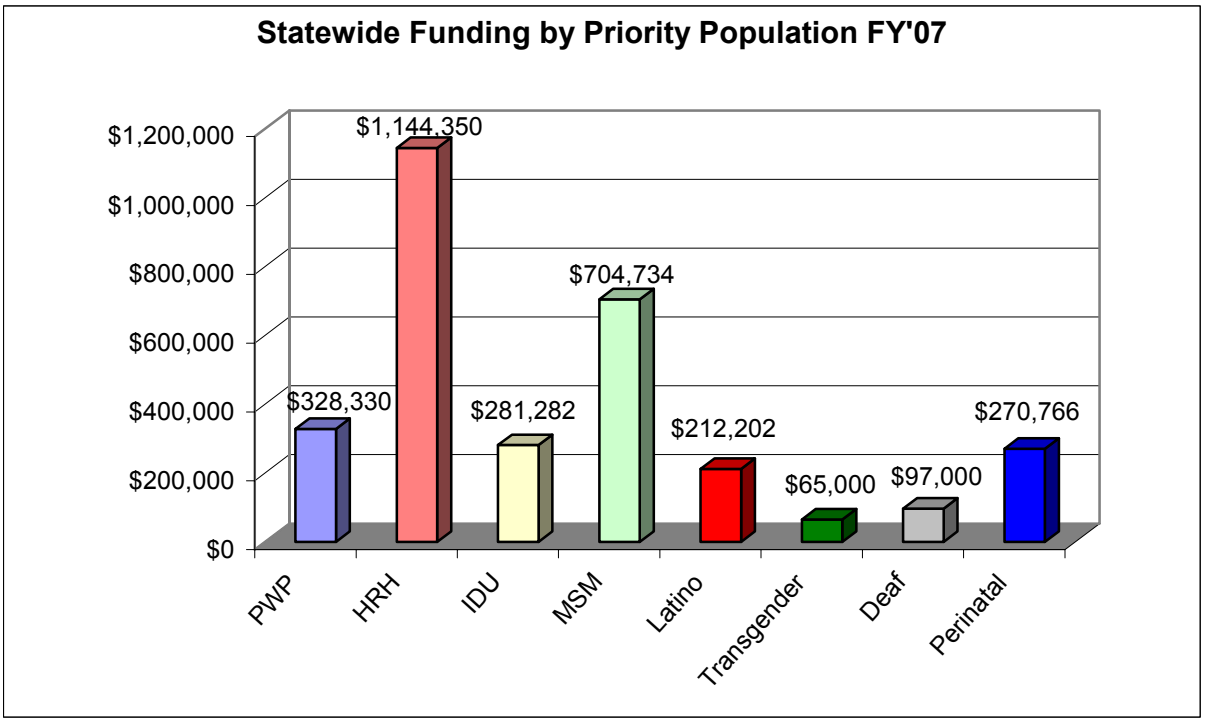
The following acronyms are used extensively in the CSA:

HRH – High-Risk Heterosexual
HRW – High-Risk Women
HRM – High-Risk Men
HRY – High-Risk Youth
MSM – Men who have Sex with Men
PWP – Prevention with Positives
CTR –Counseling, Testing and Referral
IDU – Injecting Drug Users
PCRS – Partner Counseling and Referral Services

Funding

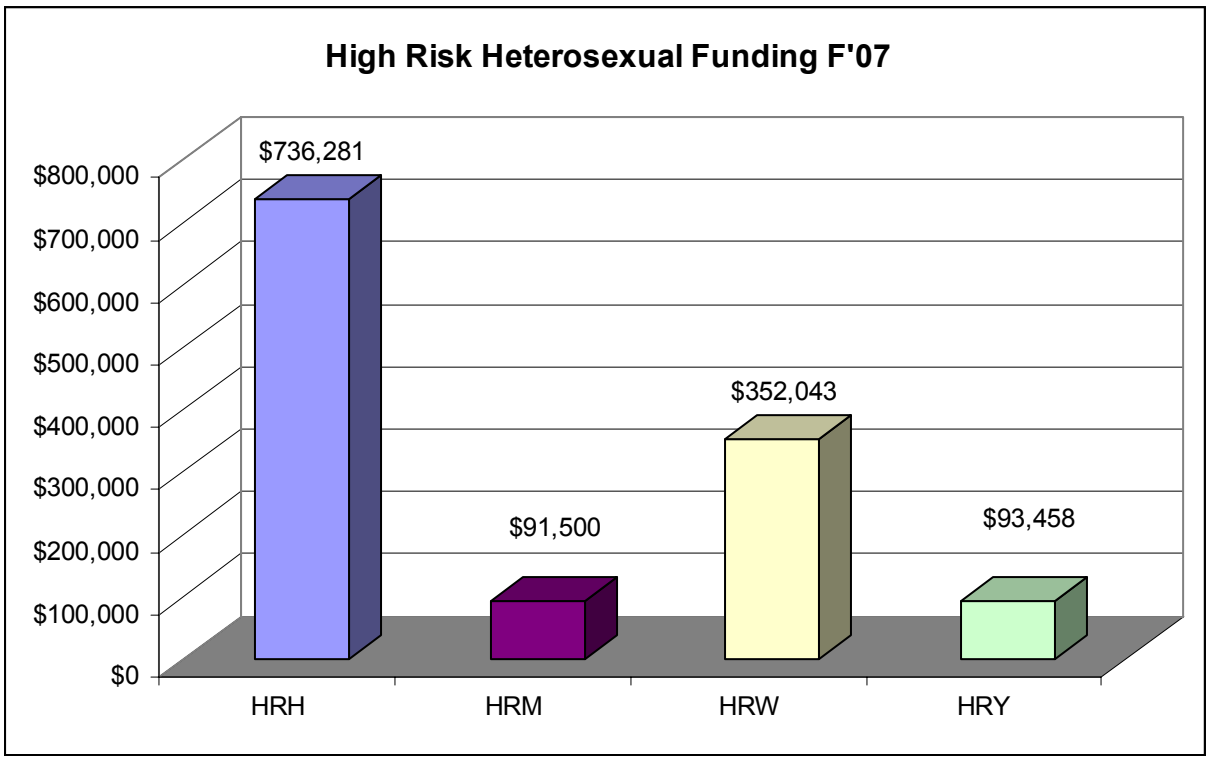
The charts below represent funding allocated for fiscal year 2008. This covers the period between July 1, 2006 and June 30, 2007. The funding represented here was voted on and approved by the CPG in June 2007.

Funding by Priority Population



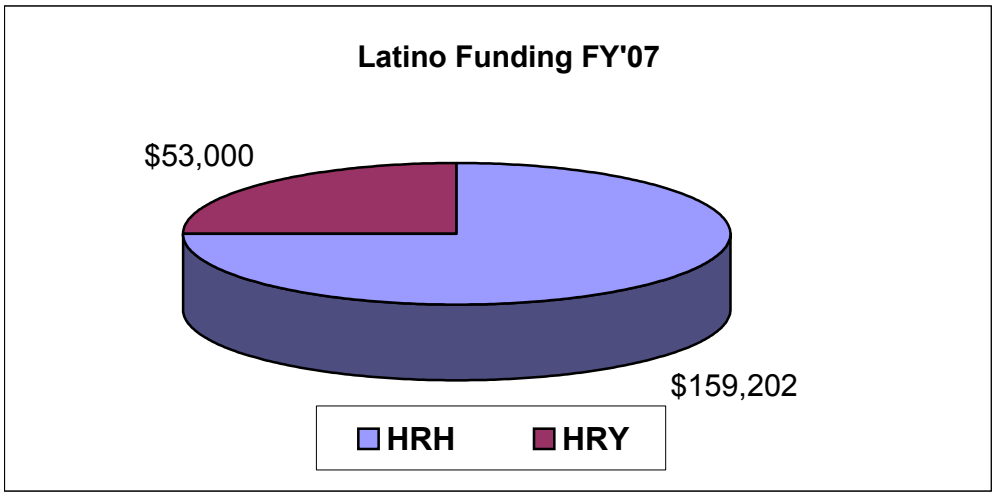
This chart reflects both Maryland's response to CDC's Advancing HIV Prevention for Positives Initiative and the continued allocation of funds in proportion to population priority. This is the second year Perinatal programs were included in the CSA. Although it is not included in the priority populations, Perinatal transmission is a key area covered by Maryland's prevention funding.

HETEROSEXUAL Funding



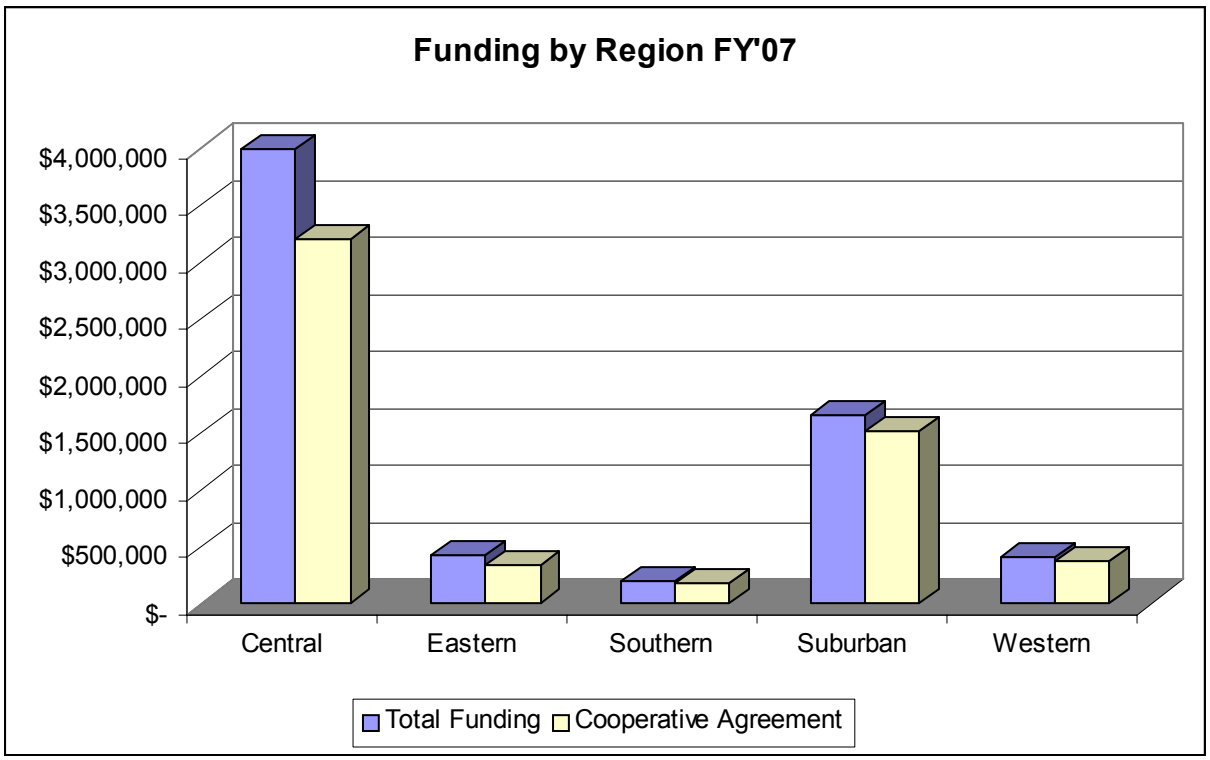
This year a concerted effort was made to break populations down based on the target group within High Risk Heterosexual (HRH) programs. The money that is classified as HRH is directed towards programs that are truly co-educational. As the chart shows, a larger proportion of the heterosexual funding goes to programs directed at women rather than those directed at men. This reflects the epidemiological data that shows that women outnumber men as a proportion of new heterosexual infections.

Latino Funding



The majority of Latino funding goes to HRH programs. Currently, Latino programs are limited to the Central and Suburban regions. Funding for the Migrant Worker Project on the Eastern Shore is not included in the chart above.

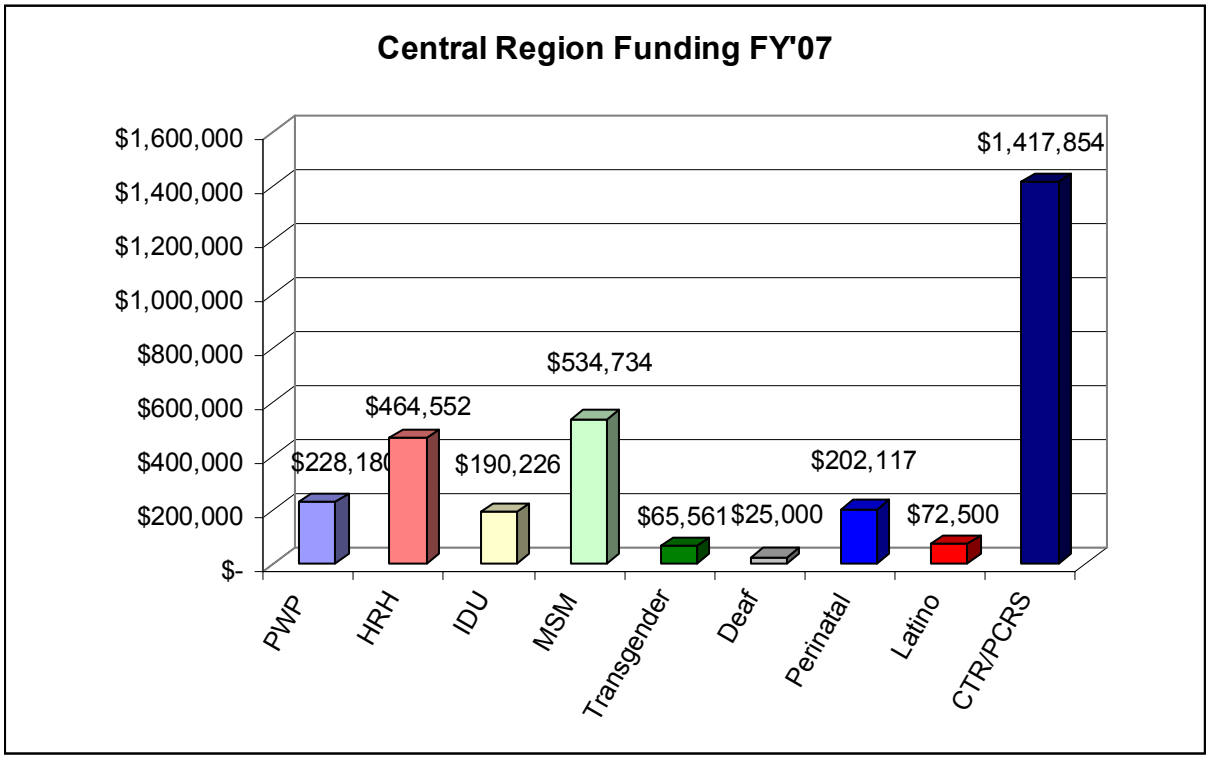
FUNDING DISTRIBUTION BY REGION FY'06

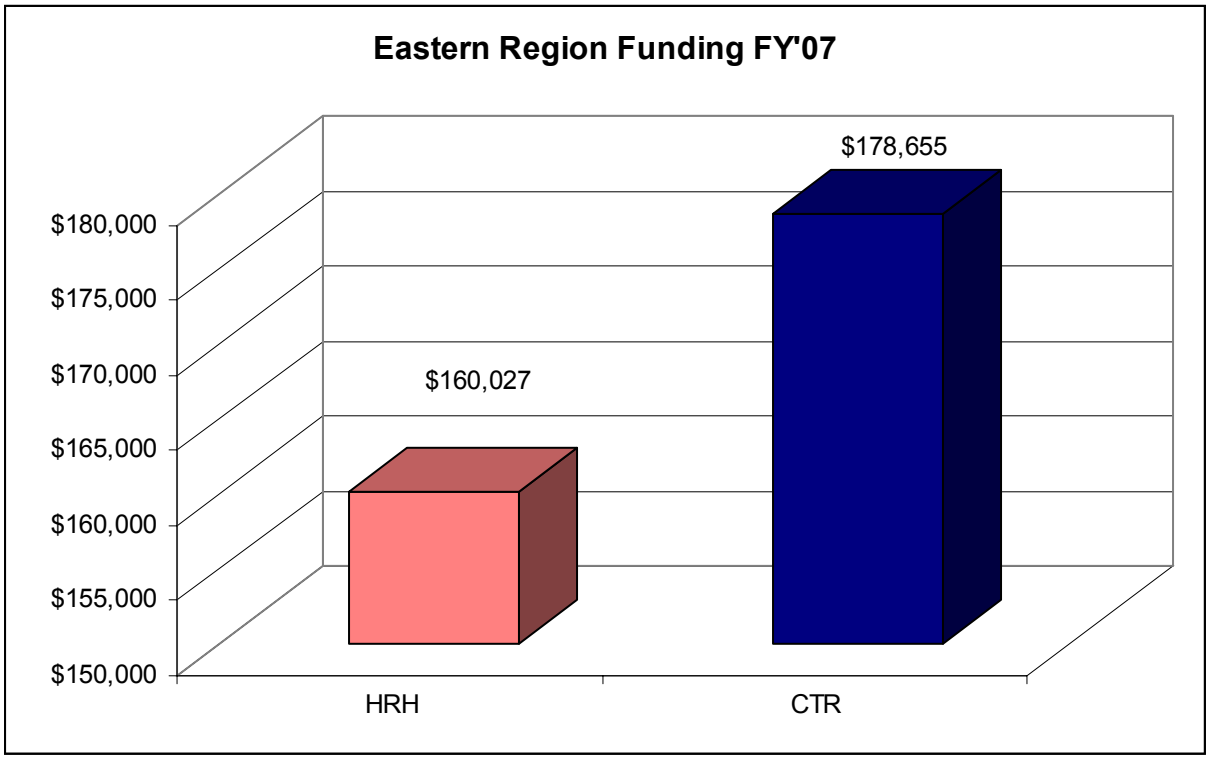


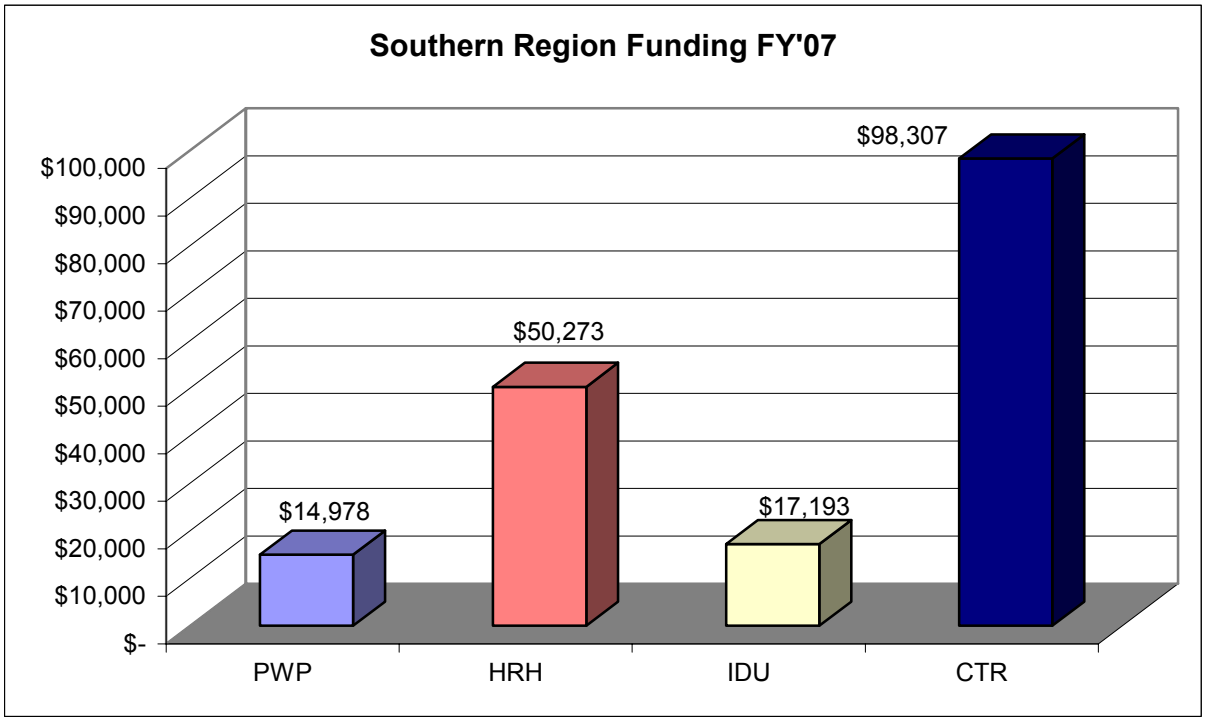
As previously stated, the majority of those impacted by the epidemic reside in the Central and Suburban regions. It is for this reason that the funding distribution appears as it does, with funding being allocated to regions most affected by the epidemic. Please see Appendix B for additional information regarding the development of the allocation formula and HIV Prevention Planning Budget. This graph reflects Health Education/Risk Reduction programs, Counseling, Testing and Referral, Partner Counseling and Referral Services, and region-wide programs that draw their funding from the regional allocation.

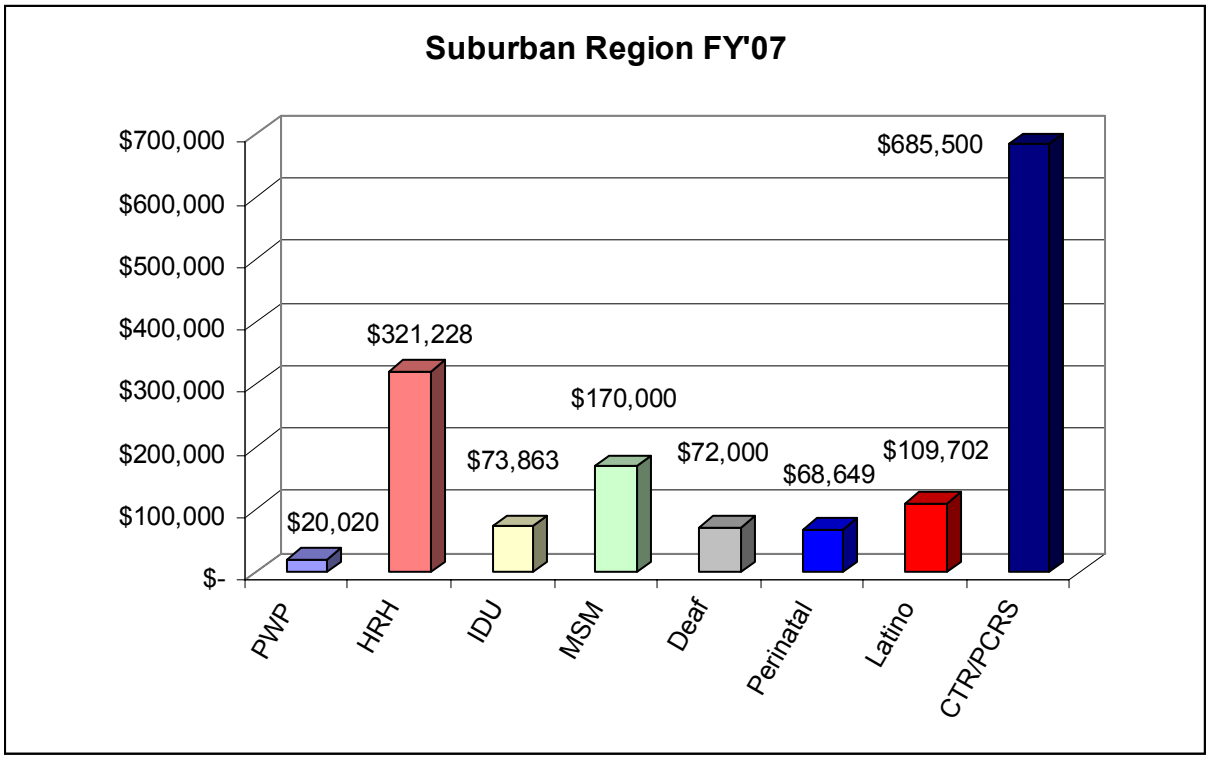
FUNDING BY PRIORITY POPULATION ACROSS REGIONS

The following bar graphs illustrate the funding distribution by priority population across each of the regions – Central, Eastern, Southern, Suburban and Western. Despite the relatively low dollar amount, PWP programs continue to expand in response to the CDC directive ranking HIV positive individuals as the number one priority. CTR/PCRS is also a growing focus. Also reflected in the funding patterns is the large proportion of new infections among heterosexuals in Maryland. The remainder of the funding distribution for each region is determined by the scope of the epidemic within that region and the capacity of vendors to reach priority populations.




Eastern Region Funding FY'07
$180,000
$175,000
$170,000
$165,000
$160,000
$155,000
$150,000
$160,027
$178,655
HRH
CTR


Southern Region Funding FY'07
$100,000
$90,000
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$-
$14,978
$50,273
$17,193
$98,307
PWP
HRH
IDU
CTR


Suburban Region FY'07
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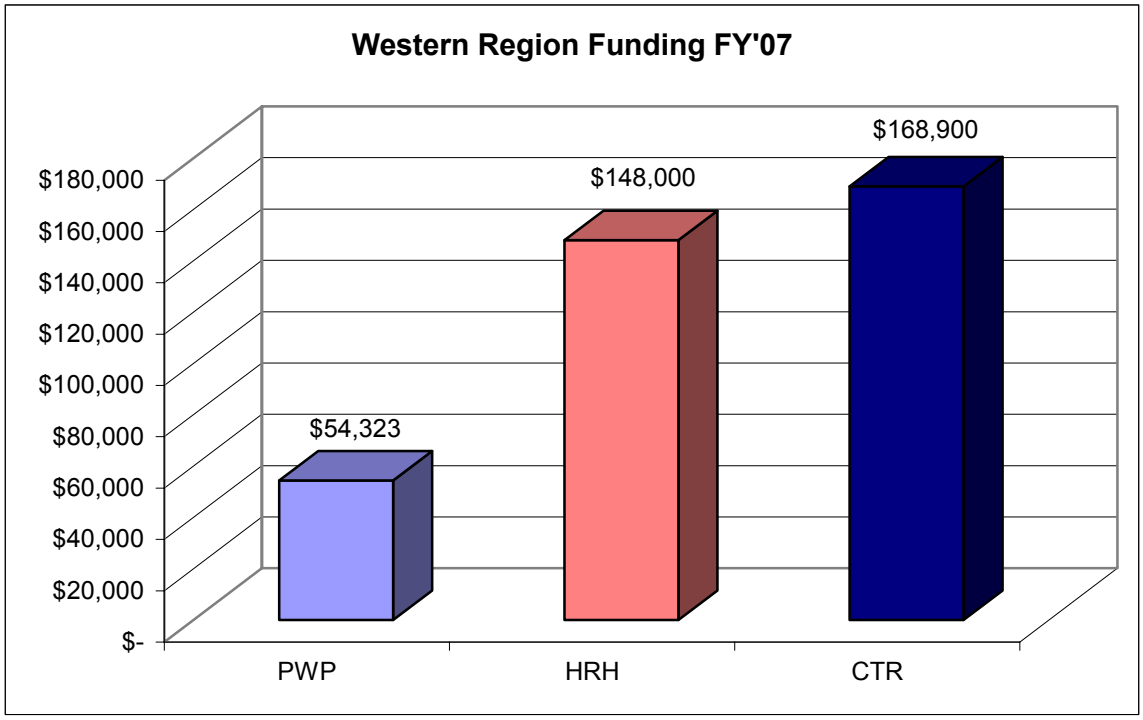
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
$20,020
$321,228
$73,863
$170,000
$72,000
$68,649
$109,702
$685,500
PWP
HRH
IDU
MSM
Deaf
Perinatal
Latino
CTR/PCRS


Western Region Funding FY'07
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$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$-
$54,323
$148,000
$168,900
PWP
HRH
CTR

SECTION FIVE:
Priority Setting and Identified Populations
Prioritized Interventions

Priority Setting and Identified Populations

One of the improvements made to the process in May 2004 was the CPG's adoption of a set of decision rules to guide future decision-making, including priority setting. The Program Advisory Committee of the CPG proposed the following rules, and the CPG adopted them at their May 2004 meeting:

1. *Target populations should be defined by (risk) behavior. (Thus, risk categories, rather than demographic groups, should be ranked.)*
2. *Priority setting should be based on epidemiologic data.*
3. *Specifically, priority setting should be based on HIV incidence data, rather than AIDS prevalence data, because they are more current.*
4. *Decisions should be based on data specific to the target project area (e.g., Maryland) where possible.*
5. *Decisions should be based on evidence that is "current"(no older than three years) and "relevant" (specific to the target population).*

Decisions should be made based on evidence that can be shared and reproduced.

The Maryland Community Planning Group (CPG) approved Maryland's HIV prevention priorities in May 2005 by unanimous vote. In 2006 the CPG voted to keep the Priority Populations the same. The prevention priority populations are ranked as follows:

Maryland HIV Prevention Priorities

1. HIV Positive Persons
2. Heterosexuals (86% African American)*
3. Injection Drug Users (IDU) (85% African American)*
4. Men Who Have Sex With Men (MSM) (71% African American)*
5. Special Populations

*African American percentages were developed by averaging the percentages of clients within each transmission group (heterosexual, IDU, and MSM) who were African American during the three most recent years, i.e. during 2002, 2003, and 2004.

When aggregated, the HIV prevention projects targeting each risk group should serve mostly African Americans. *Individual* projects do not have to meet these racial goals. e.g., when client level data from all IDU projects are added together, *85%* of the IDU served should be African American IDU. These priority populations reflect the Centers for Disease Control and Prevention (CDC) requirements and the risks associated with new HIV infections in the state. Within each priority population (i.e. heterosexual), high risk groups (i.e. women), as defined by HIV prevalence or individual risk behaviors, are

also prioritized. Furthermore, within each risk group African Americans are emphasized, given the disproportionate impact of HIV in this group.

Rationale
The priorities are based on CDC and community planning inputs, epidemiologic and targeting considerations.

CDC Inputs
The CDC requires that states have one set of statewide HIV prevention priorities. The CDC requires that persons living with HIV/AIDS be ranked #1 on this list. The CDC emphasizes the use of epidemiologic data in priority setting.

Community Planning Inputs
The CPG and the CDC are redirecting HIV prevention programming away from education-only to behavioral counseling, skills-practice interventions. HIV prevention programs should offer participants a safe space to confront real life barriers to putting HIV prevention information into practice in their lives.

Epidemiologic Considerations
Per the CPG's decision rules for priority setting, the statewide prevention priorities are based on trends in HIV incidence.

Targeting Considerations
Behavior, not membership in racial groups, puts people at risk for HIV infection. In addition, CDC requires that prevention programs be targeted, organized, and evaluated by risk factors. Ranking by risk helps the CPG to analyze linkages among the Plan, Application, and funded programs.

Special Populations
Special Populations are defined as those with special linguistic needs and/or those who are at documented elevated risk of HIV transmission and who are unlikely to be served by prevention programming targeting one of the above risk groups. *Examples* include the Deaf, Latino, and Transgender populations. Grouping special populations together responds to the reality that data on these populations are emerging, and allows programming to respond to this dynamic climate. Programming will be targeted to respond to the evidence about the most affected age groups within each risk category.

Prioritized Interventions

In June of 2003, the CPG completed our 2004-2008 HIV Prevention Plan and submitted it to the CDC. However, in the Fall of 2003, the CDC issued new guidance that requires CPGs to rank HIV positive persons as the number one priority population and to identify the other priority populations by relying heavily on epidemiological data. The guidance also required CPGs to have one statewide plan instead of regional plans. For these reasons the CPG revised the HIV Prevention Plan.

As previously mentioned, one of the improvements made to the process May 2004 was the CPG's adoption of a set of decision rules to guide future decision-making, including priority setting.

These decision rules aim to bring fairness and objectivity to what can be an emotional and politically charged decision process.

In September 2004, the CPG's Executive Committee reviewed the 2004 Health Department Interim Progress Report and concurred that it was responsive to the 2004-2008 priorities.

The next task for the CPG was to develop a list of interventions for the statewide priority populations. At the CPG Retreat, the CPG began developing a list of interventions by combining the identified regional interventions into a statewide list of interventions for each priority population. The attempt to consolidate five regional sets of priorities into one produced a very large number of recommended interventions per statewide priority population—more than can be addressed with limited CDC funds.

The interventions the CPG selects will be entered into PEMS (The CDC Program Evaluation and Monitoring System). PEMS will evaluate and monitor our program data to see if it reflects our HIV Prevention Plan. The CPG has had success in making sure priority *populations* were funded as ranked in the plan. However it is more difficult to ensure that all the *interventions* listed in the HIV Prevention Plan are funded.

AIDS Administration Health Education Risk Reduction (HERR) program managers, Counseling Testing and Referral (CTR) staff, and Partner Counseling and Referral Services (PCRS) staff were asked to participate in the exercise to assist CPG members in finalizing and prioritizing the interventions. During the February 10, 2005 meeting, breakout committees were formed to prioritize the recommendations for interventions. The recommendations were as follows:

- Positives – Individual Level Intervention (ILI), Group Level Intervention (GLI), Counseling Testing and Referral Services (CTR), Outreach and Health Communications.
- Heterosexuals – GLI, ILI, Public Information, CTR and Partner Counseling and Referral Services (PCRS).
- IDU – GLI, Skills Training, Prevention Case Management (PCM) and PCRS.
- MSM – GLI, ILI, Community Level Intervention, CTRS
- Latinos – Skills Training, CTR, Risk Assessment for ILIs, Assist providers with complying to the Federal Law regarding language proficiency, especially targeted to areas of the state that are seeing an increase in the Latino population like Western region and some areas of the Eastern shore.
- Trans-Gender – ILI, Provider Education

Deaf population – CTRS, and Health Communication/Public Information.

SECTION SIX:
Indicators

An indicator is a piece of information that gives insight into the performance of something. Performance indicators as they relate to HIV Prevention planning promote good management and provide tools to measure performance in a way that emphasizes results. Indicators do not inform us about extraneous factors, which may influence the indicators, and they do not measure anything outside of their scope (or what they were created to measure). The CPG will be able to consider indicators of program success in CTR, HERR, PCRS, Prevention with Positives, Evaluation, Planning, etc. in updating the HIV Prevention Plan each year.

The CPG believes that the following factors ought to be considered when the state health department allocates resources in each of these required areas:

- cost and cost effectiveness;
- progress toward goals;
- outcome effectiveness;
- the size of the target population (persons at risk, agencies, volunteers) needing the intervention;
- the cultural, social, and economic status of the target population;
- the presence (or absence) of well-developed logic models supported by behavioral theories and specified interventions with appropriate evaluation measures;
- national goals; and
- input from community planning.

The CPG learned the possible use of program performance indicators as a means of evaluating progress toward program goals, and as data sources for decision-making about funding including reduction, discontinuation, maintenance, and expansion of efforts. Capacity building efforts should be directed toward improving the performance of program areas aimed at prevention goals. Annual analysis of the extent and success of capacity building efforts should also inform the direction and redirection of capacity building resources.

Following are program performance indicators for statewide, multi-regional, and local program areas:

Prevention for HIV-infected Persons

- Percent of HIV positive participants reporting a reduction in sexual or drug using risk behaviors or maintaining protective behaviors with seronegative partners or with partners of unknown status.

Community Planning

- Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one CPG member that reflects the perspective of each population.
- Proportion of CPG membership that agrees that key attributes of an HIV prevention planning process have occurred.
- Proportion of prevention interventions and supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.
- Proportion of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

HIV Counseling and Testing

- Percent of newly identified, confirmed HIV-positive test results among all tests reported by CDC-funded HIV counseling, testing and referral sites.
- Percent of newly identified, confirmed HIV positive test results returned to clients.
- Percent of facilities reporting appropriately targeted HIV testing services.

Partner Counseling and Referral

- Percent of contacts receiving an HIV test after PCRS notification.
- Percent of contacts with a newly identified, confirmed HIV-positive serostatus among all contacts.
- Percent of contacts with confirmed HIV positive serostatus among all contacts.

Perinatal Prevention

- Proportion of women who receive an HIV test during pregnancy.
- Proportion of HIV-infected pregnant women who receive appropriate treatment for prevention of perinatal transmission.
- Proportion of HIV-infected pregnant women whose infants are perinatally infected.

Monitoring and Evaluation

- Proportion of providers reporting complete process monitoring data to the health department in compliance with CDC program announcement.
- Proportion of providers reporting complete outcome monitoring data to the health department in compliance with CDC program announcement.

Capacity Building

- Proportion of providers who have received health department supported capacity building assistance (training or technical consultation) in the design, implementation or evaluation of science-based HIV prevention interventions.
- Proportion of providers reporting increased capacity for the design, implementation, or evaluation of science-based HIV prevention interventions.

For more performance indicator information please see Appendix C.

SECTION SEVEN:
Letter of Concurrence

AIDS Administration
Heather L. Hauck, MSW, Director

August 15, 2007

Sheri Disler
Grants Management Officer
Procurement and Grants Office
Centers for Disease Control and Prevention
290 Brandywine Road
Room 300, Mailstop E-15
Atlanta, GA 30341

Dear Ms. Disler:

At its June 6, 2007 meeting, the Maryland HIV Prevention Community Planning Group (CPG) voted to concur, without reservation, with the state of Maryland's application to CDC for HIV prevention funds under program announcement 04012. As Co-Chairs of the CPG, we believe that the 2008 Plan and Application reflect the will of the CPG and submit that a thorough review process was used to reach concurrence.

The AIDS Administration organized and delivered a series of presentations and activities from January to June 2007 which built the capacity of the CPG to understand and analyze the overall prevention program described in the 2008 budget application. Presentations included HIV reporting, Partner Counseling and Referral Service (PCRS) and HIV prevention efforts with People Living with HIV/AIDS. Instead of a regular meeting in March the CPG was provided a community planning training day. The training day included an overview of the purpose of the CPG; the planning cycle; ranking priority populations; and a review of how to interpret the AIDS Administration budget.

In April 2007, the CPG reviewed current Maryland HIV epidemiological data and affirmed that the ranking of priority populations was still reflective of the impact of the HIV epidemic in the state of Maryland. The epidemiology presentation included maps of HIV/AIDS incidence and prevalence rates, trends by HIV exposure and demographics per regions in Maryland. In May 2007, the CPG developed prioritized interventions for People Living With HIV/AIDS (PLWHA). Members recommended that PCRS be included in interventions targeting PLWHA

At the June 2007 CPG meeting, the proposed 2008 application budget was presented. The presentation outlined the numerous budget influences and decision principles used to generate the budget. The CPG used the updated HIV prevention Plan to guide the review of the proposed Maryland HIV prevention budget. During the

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Toll Free 1-800-358-9001 • TTY for Disabled – Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.state.md.us/AIDS/

APPENDIX A:
Charter for Maryland CPG

CHARTER
FOR THE
STATE OF MARYLAND
HIV PREVENTION COMMUNITY PLANNING GROUP
As revised May 5, 2005

Article I. Name

The name of the Planning Group shall be the Maryland HIV Prevention Community Planning Group (CPG)

Article II. Mission

The overall mission of the CPG is to develop and monitor the effectiveness of a Comprehensive HIV Prevention Plan for the State of Maryland.

This mission will be accomplished in collaboration with the Department of Health and Mental Hygiene by carrying out these necessary steps (*From Supplemental Guidance, 12-17-93, Section H*) in HIV Prevention Community Planning:

A. Assessing the present and future extent, distribution, and impact of HIV/AIDS in defined populations in the community;
B. Assessing existing community resources for HIV prevention to determine the community's capability to respond to the epidemic. These resources should include fiscal, personnel, and program resources, as well as support from public (Federal, state, county, municipal), private, and volunteer sources. This assessment should identify all HIV prevention programs and activities according to defined high-risk populations;
C. Identifying unmet HIV prevention needs within defined populations;
D. Defining the potential impact of specific strategies and interventions to prevent new HIV infections in defined populations;
E. Prioritizing HIV prevention needs by defined high-risk populations and by specific strategies and interventions;
F. Developing a Comprehensive HIV Prevention Plan consistent with the high priority HIV prevention needs identified through the HIV Prevention Community Planning process; and
G. Evaluating the effectiveness of the planning process.

The Department of Health and Mental Hygiene will develop an application for Federal funds for HIV Prevention based on the Comprehensive HIV Prevention Plan. The CPG

will be asked to assess the responsiveness and effectiveness of this funding application in addressing the priorities identified in the Comprehensive HIV Prevention Plan and vote its concurrence or non-concurrence. Furthermore, the Comprehensive HIV Prevention Plan may also be used to secure other additional funds.

The CPG will also monitor the effectiveness of the implemented plan in delivering HIV prevention services to high priority, high-risk populations in Maryland.

Article III. Roles and Responsibilities

Section 1. Role of the CPG. The role of the CPG (*From Supplemental Guidance, 12-17-93, Section H)* and its designated committees in the HIV Prevention Community Planning process is to:

A. Delineate technical assistance and capacity development needs for effective community participation in the planning process.
B. Review available epidemiologic, evaluation, behavioral and social science, cost effectiveness, and needs assessment data and other information required to prioritize HIV prevention needs, and collaborate with the health department on how best to obtain additional data and information.
C. Assess existing community resources to determine the community's capability to respond to the HIV epidemic.
D. Identify unmet HIV prevention needs within populations.
E. Prioritize HIV prevention needs by target populations and propose high priority strategies and interventions.
F. Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation.
G. Consider how a) counseling, testing, r eferral, and partner notification (CTRPN), early intervention, primary care, and other HIV-related services; b) STD, TB, and substance abuse prevention and treatment; c) mental health services; and d) other public health needs are addressed within the Comprehensive HIV Prevention Plan.
H. Evaluate the HIV Prevention Community Planning process and assess the responsiveness and effectiveness of the Department of Health and Mental Hygiene's application in addressing the priorities identified in the Comprehensive HIV Prevention Plan.
I. Provide input and participate in the development of the budget application.

Section 2. Shared Responsibility. Responsibility will be shared between the Department of Health and Mental Hygiene and the HIV Prevention CPG (*From Supplemental Guidance, 12-17-93, Section H)*

A. Select Co-Chairs for the HIV Prevention CPG: Department of Health and Mental Hygiene selects a department employee, or a designated representative as one Co-Chair, and the CPG selects the other.

B. Develop procedures that address (a) policies and provisions for reaching decisions on attendance at meetings; (b) resolution of disputes identified in planning deliberations; and (c) resolution of conflict(s) of interest for members of the CPG.

C. Determine the distribution of planning funds to (a) support capacity development for parity, inclusion, and the effective participation of members in the CPG; (b) provide technical assistance by outside experts to Department of Health and Mental Hygiene and CPG; (c) support community health planning infrastructure for the HIV Community Planning process; (d) collect and/or analyze and disseminate relevant data; (e) support other identified needs of the CPG, and (f) support regional community forums, town meetings, and/or focus groups to be held during the planning process.

D. Assess the present and future extent, distribution, and impact of HIV/AIDS in defined populations in Maryland.

E. Conduct a needs assessment process to identify unmet HIV prevention needs within defined populations.

F. Identify specific high priority strategies and interventions for defined target populations.

G. Develop goals and measurable objectives for HIV prevention strategies and interventions in defined target populations.

H. Integrate multiple HIV community prevention plans into a state-wide Comprehensive HIV Prevention Plan and foster integration of the HIV Prevention Community Planning process with other relevant planning efforts.

I. Develop and periodically update a Comprehensive HIV Prevention Plan including the provision of technical assistance to meet the needs of the Department of Health and community-based providers in the areas of program planning, implementation, and evaluation.

Section 3. Individual Responsibilities. The specific responsibilities of the CPG members, the Co-Chairs, its consultants, and the members of the Executive Committee are outlined in job descriptions.

Article IV. Membership

Section 1. Number. The CPG shall consist of no less than 30 voting members and 6 ex-officio non-voting members, the Principal Investigator of the Prevention Cooperative Agreement, a representative from the DHMH Mental Hygiene

Administration, a representative from the DHMH Developmental Disabilities Administration, a representative from the Communicable Diseases Division, a representative from the State Department of Education, and a representative of the Alcohol and Drug Abuse Administration. Collaboration with the local Ryan White Title I Planning Councils is also encouraged. A vacancy shall not prevent the CPG from conducting business.

Section 2. Appointment and removal. Nominations for membership are identified through circulation of an invitation letter and nomination forms to: local health departments in Maryland; mailing lists of community based organizations and AIDS service organizations; newspapers and community newsletters; and radio stations for public service announcements. Candidates are selected by a representative committee, comprised of one (1) staff member of the AIDS Administration designated by the director and is open to all members of the CPG assuring an intermix which will reflect representation for all 5 regions. (The elected Co-Chair shall represent his/her region on this committee.) The Membership Committee reviews all nominations, compares them to the criteria required, and recommends individuals to the Director of the AIDS Administration for appointment to the CPG.

The Executive Committee shall have the right to recommend removal of CPG members with cause. A two-thirds (2/3) majority of the Committee is required for removal. If a CPG member has two absences, it is grounds for a letter from the Executive Committee.

If a CPG member has four absences during one planning year, defined as November 1 to October 31 of the following year, they will be recommended to the Director of the AIDS Administration for removal.

Section 3. Proxies. A CPG member may not designate a proxy to attend a meeting in his or her absence, unless that member is HIV infected:

A. This privilege is limited to 20% of the meetings within a planning year.

B. A member will designate one proxy for the planning year.

C. The proxy may not be a current member of the CPG.

D. This privilege does not extend to the Executive Committee meetings.

Section 4. Vacancies. Vacancies on the CPG will be filled from a current listing of qualified nominees solicited by public announcement as deemed necessary.

Section 5. Chairs. The Department of Health and Mental Hygiene will select an employee, or a designated representative as one Co-Chair, and the CPG will select the other Co-Chair at the December meeting of the CPG. The Co-Chairs share responsibility for guiding the Planning Group in accomplishing its mission and goals.

Article V. Governance of Meetings

Section 1. Attendance. The CPG will conduct eight meetings per year with additional meetings scheduled as necessary. Members are expected to attend all meetings of the CPG. If a member misses two meetings within a planning year, the member will receive a letter from the Executive Committee. After four absences during a planning year, the member will be recommended to the Director of the AIDS Administration for removal. A member must attend a majority of the meetings within a planning year to be eligible to attend the annual Retreat. Special consideration will be made for persons with chronic health problems, including HIV/AIDS.

Section 2. Agenda. The agenda will be prepared by the two Co-Chairs of the CPG in consultation with the AIDS Administration, its consultants, the Executive Committee, and CPG members as necessary.

Section 3. Open to public. Meetings of the CPG are open to the public for observation with a specified period for participation and will be described as such in appropriate newspapers, newsletters, and other announcements. Opportunities will be provided for public participation in the planning process.

Section 4. Decision making.

A. Procedure. The CPG will function as a committee of the whole, thus full and free discussion can be had, within specified time limits, based on an agenda approved by the CPG. When group action is deemed necessary or desirable, Roberts Rules of Order will be invoked and followed.

B. Voting. Two-thirds (2/3) of the voting members of the CPG excluding vacancies, shall constitute a quorum for the transaction of business. The action of a majority of the members present at a meeting at which a quorum is present is sufficient to approve any matter which properly comes before the meeting.

C. Dispute Resolution. When disputes arise which cannot be handled adequately under Roberts Rules of Order, the Co-Chairs are empowered to convene the Executive Committee to consider the dispute. The

Executive Committee is authorized to produce a resolution after affording an opportunity for the disputants to be heard. The Executive Committee will seek to assure understanding of the issues involved in the dispute and alternative resolutions possible before determining the preferred resolution. The resolution determined by the Executive Committee must be reported to the CPG at the next CPG meeting and ratified by the CPG.

Section 5. Conflict of Interest. The CPG procedures concerning conflict of interest are developed and operate within the boundaries of state law. They apply to all members appointed to the CPG by the AIDS Administration. Staff of the AIDS Administration are covered by existing state regulations. Consultants to the CPG are by contract covered to operate within the state regulations.

A. Prohibitions

1. Personal or organizational financial gain by CPG members is prohibited. Financial gain for organizations represented by the members is likewise prohibited.

2. No member may divulge designated confidential information acquired in the course of official CPG duties in advance of authorized release time.

3. No member may misrepresent the position of the CPG.

4. No member may request funds except as reimbursement for travel-related expenses incurred while doing authorized CPG business.

5. No member may request funds for salary from the CPG.

B. Disclosure

1. Each CPG member shall disclose all real or potential conflicts on an AIDS Administration disclosure form. The disclosure form must be signed prior to serving on the CPG.

2. Each CPG member shall specify personal associations that might benefit from activities or decisions of the CPG.

C. Procedures. Any CPG member who has disclosed or been found to have a conflict of interest in relation to a particular matter must not:

1. Participate in the discussion of that matter.

2. Vote on funding decisions.

D. Determination

1. When a CPG member believes another member may be caught in conflict, that member's privilege to participate may be challenged during the discussion. The CPG or its Executive Committee shall decide whether or not the member should be excluded.

2. If a CPG member believes another member to have a real or potential conflict, the CPG Co-Chairs shall be notified and the matter referred to the Executive Committee for action.

Article VI. Committees and Task Forces

Section 1. General. Committees or task forces may be appointed by a majority vote of the CPG to address specific tasks or other work, e.g. background work on a specific issue, the results of which are then presented to the entire CPG for information or official action.

Section 2. Executive Committee. The CPG will elect an Executive Committee consisting of seven (7) members; six (6) voting members, including the two (2) Co-Chairs and one (1) non-voting member, who shall be the Principal Investigator of the Prevention Cooperative Agreement. Two-thirds (2/3) of the voting members of the Executive Committee, excluding vacancies, shall constitute a quorum for the transaction of business. The action of a majority, where a quorum is present, is sufficient to approve matters brought before the Executive Committee. Any actions of the Executive Committee will be reported to the CPG for review or ratification, when necessary, at its next meeting.

Section 3. Regional Work Groups. In conjunction with the AIDS Administration, the CPG will maintain five (5) regional committees of the CPG, called Regional Work Groups (RWGs), one for each of the geographic planning regions of the state.

Purpose and Responsibilities: The major purpose of the Regional Work Groups is to involve community members throughout the State of Maryland in the important work of HIV prevention planning. The primary responsibility of the RWGs is to assess the need for HIV prevention services in their respective geographic region, using scientific and behavioral data and constituency input. Using the data and community input, each RWG will establish and rank HIV prevention activity statements for their region. These prioritized prevention statements are recommendations that are forwarded to the CPG for review, approval, and inclusion in the statewide HIV prevention plan. Along with the CPG, the RWGs will review the relevant portions of the AIDS Administration's annual application to the CDC and recommend changes to enhance the

consonance between the regional priorities and resource allocations. Finally, the RWGs may undertake supplementary planning tasks relevant to and consistent with the primary responsibility of regional planning, as stated above. Each RWG may develop and implement guidelines or policies for voting and decision making to be used by that RWG during the regional portion of the statewide HIV prevention planning process. Any additional RWG activities, as well as RWG voting and decision making policies and procedures must be consistent with the purpose and responsibilities of the CPG as determined by the Organizing Documents.

Membership: Membership in the RWG is open to all interested parties. In order to minimize barriers and to encourage participation by members of the community who are infected and/or affected by HIV/AIDS, there is no application or appointment process for becoming a member of the RWG and there are no term limitations. This provides an opportunity for all citizens of Maryland to participate in the HIV prevention needs assessment and priority setting process and helps to ensure parity and equity at the grassroots level of planning.

Leadership: Each Regional Work Group will be led by two (2) Co-Chairs. One (1) Co-Chair is a member of the CPG, and is called the RWG/CPG Co-Chair, and one (1) is a community member, not from the CPG, and is called the RWG/Community Co-Chair. To be eligible for the RWG/CPG Co-Chair position, a person must have already been appointed to the CPG.

Article VII. Books and Records

The CPG shall keep minutes of all proceedings of the CPG, a summary of major decisions, and such other books and records as may be required for the proper conduct of its business and affairs.

Article VIII. Amendments

This Charter may be amended at any regular or special meeting of the CPG. Written notice of the proposed Charter change shall be mailed or delivered to each member at least 5 days prior to the date of the meeting. Charter changes require a two-thirds (2/3) majority vote of the CPG members.

Article IX. Ratification

This Charter goes into effect upon a two-thirds (2/3) majority vote of the CPG members.

Article X. Dissolution

This CPG has been formed to assist the Department of Health and Mental Hygiene in the HIV Prevention Community Planning Process. Unless the CPG selects otherwise, and builds a new Charter, the CPG will be dissolved when the CPG, in consultation with the Maryland AIDS Administration, assesses no continuing need for the group.

Article XI. Non-Discrimination

The CPG shall not engage in discriminatory practices in violation of applicable law.

Article XII. Election Procedures

Section 1. CPG. All CPG elections will take place by written ballot. When the number of vacancies is equal to the number of nominees, election may occur by acclamation. Elections of the CPG Community Co-Chair and the CPG Executive Committee occur in December of each year, or when vacancies occur. In the case of vacancies, the elected member shall serve the unexpired term of office. The elected person shall not be precluded from seeking a full term of office unless it is otherwise prohibited elsewhere in this document. Elections of all other committee chairs and Co-Chairs succeed the election of these officers.

Section 2. RWG Co-Chairs. Both the RWG/CPG and RWG/Community Co-Chairs will be elected by all participants present at the RWG election meeting. At this meeting each CPG and community member present will cast one vote for the RWG/CPG Co-Chair candidate of their choice and one vote for the RWG/Community Co-Chair candidate of their choice. Ballots are tabulated and election results are finalized. This election will be conducted by written ballot and the results reported back to the CPG.

APPENDIX B:
2006 HIV Prevention Budget and Allocation Formula

2006 HIV Prevention Budget

The Prevention Planning budget is determined yearly based upon CDC Award amounts, Administrative costs and the Allocation Formula. The Allocation Formula description and rationale are discussed in the following section. Below is the 2006 HIV Prevention Budget approved by the CPG.

Total Award from CDC	$	10,099,652
Administrative Costs		
State Employee/Supplies/Equipment/Other/Indirect	$	2,739,764
Funding Available for Non-Regional Projects	$	1,446,576
Funding Available for Regions (Allocation Percentage*)	$	5,612,342
Central (57%)	$	3,200,724
Eastern (6%)	$	338,682
Southern (3%)	$	180,751
Suburban (27%)	$	1,520,962
Western (7%)	$	371,223

* Explanation in Following Section

Allocation Formula

Formula for the Distribution of Federal Funding by Region According to Need Origins, Rationale, and Application

The Maryland Department of Health and Mental Hygiene (DHMH) AIDS Administration receives funding from the U.S. Centers for Disease Control and Prevention (CDC) to conduct activities in Maryland to reduce the spread of HIV infection. For calendar year 2002, the AIDS Administration has applied for $11 million in support for HIV prevention activities. For purposes of HIV prevention planning and implementation, Maryland is divided into five geographic regions[1].

[1] Following each region is its jurisdictional composition:

Central MD	Anne Arundel, Baltimore, Carrol, Harford, Howard counties; Baltimore city
Eastern MD	Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester counties

The AIDS Administration is committed to the concept of vertical equity in its distribution of resources. Rather than distribute funding equally among all jurisdictions (horizontal equity), the AIDS Administration distributes resources in accordance with the disparate impact of the HIV epidemic in each geographic region. The formula for the allocation of federal HIV prevention funds is one tool to match resources to documented need. During the late 1990s, the AIDS Administration applied a regional allocation formula developed by a community advisory panel during the mid-1990s. By the year 2000, the availability of new, more reliable data sets prompted the AIDS Administration to convene a new community advisory panel to update the formula. Participants included residents of all five regions of the state, Local Health Officers, HIV Prevention Staff of Community Based Organizations, persons living with HIV/AIDS, and persons experienced in applying epidemiologic data to public policy and decision-making.

The advisory panel explored a range of data sets to include in a formula to measure the need for HIV prevention services. The panel observed that a great number of risk factors co-vary with poverty, and decided to use poverty rates as one part of the formula. They also considered population, STD, HIV and AIDS rates to be important indicators of HIV prevention need. The panel discussed the relative weight or power of each variable in the formula. It was committed to making use of the new HIV data in the formula, since AIDS data generally describes risk behavior that occurred ten years' previous.

The advisory panel agreed on the following formula to distribute federal funding among the five regions of Maryland:

Formula for the Regional Distribution of Federal Funds

Variable	Weight
Population	.2
Poverty	.3
Chlamydia cases	.1
Proportion of living HIV/AIDS cases .2	
A 3-year average of HIV incident cases	.2

The advisory panel gave the greatest power in the formula to poverty, noting that the risky situations and behaviors which HIV prevention targets co-vary with poverty. The panel included population, simply the number of people living in a region, to weight the need for HIV prevention services, by population size of the region. Chlamydia is included in the formula because it measures current sexual risk more accurately than other markers.

While population, poverty, and chlamydia measure the *risk* of HIV infection, the remaining variables in the formula measure the *burden and the risk* of the HIV epidemic in a region. The proportion of living HIV/AIDS cases in a region describes how many people are carrying HIV infection in a region. The final variable is a 3-year average of HIV incident (new) cases. Many counties in Maryland have very few new cases of HIV infection each year. One

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Southern MD Calvert, Charles, St. Mary's counties
Suburban MD Montgomery, Prince George's counties
Western MD Allegany, Frederick, Garrett, Washington counties

county may have 1 new case in 1999, ten cases in 2000, and 4 cases in 2001. It would be misleading in counties with low incidence to consider only the most recent year's numbers. Taking a *three-year average* of HIV incident cases paints a more accurate picture of the HIV epidemic in those counties.

Each year, the AIDS Administration gathers new data and "re-runs" the formula with the new data. Doing so results in minor shifts in the percentages of funding available to each of the regions. For example, most recently the Census 2000 data were released and included in the formula. Net population increases in Carroll and Frederick counties documented in the new Census data yielded a small increase in the percentage of funding allocated to the Western Maryland region.

For the AIDS Administration's Application to CDC for CY06, the percentage of funding available to each region is as follows:

Central	57.03%
Eastern	6.03%
Southern	3.22%
Suburban	27.10%
Western	6.61%

Each annual Application to the CDC contains core public health costs such as supplies and salaries. The AIDS Administration spends tens of thousands of dollars a year on condoms and oral HIV testing devices which it makes available for free to its vendors conducting HIV prevention activities including counseling and testing. The AIDS Administration spends hundreds of thousands of dollars a year on laboratory supplies, in order to make HIV counseling and testing available as infrastructure in every county in Maryland. The AIDS Administration is also obligated to contribute money to the state as a percentage of funding brought into the state (from the federal government.) In addition, some prevention programming is classified as *multiregional* because it occurs in more than one of the regions. An example is the HIV Outreach to the Deaf project which is based in Baltimore but travels to other areas of the state where Deaf persons are concentrated, such as outside Gallaudet University in Suburban Maryland, and in Frederick County near the School for the Deaf. After calculating the resources needed for infrastructure and multiregional projects, the AIDS Administration has an amount of money available for regional prevention programming. It is this total amount to which the AIDS Administration applies the regional allocation formula.

Having calculated the amount of money available for programming within a region, the AIDS Administration then consults the priorities established through the community planning process to determine the programming in each region. Maryland is fortunate to have a strong, community-driven process for HIV prevention planning. The Community Planning Group (CPG) is responsible for conducting needs assessments and establishing HIV prevention priorities for Maryland. The CPG's work is informed by five strong regional committees (Regional Work Groups--RWG) that develop regional priorities based on epidemiologic data, findings of behavioral science and efficacy studies, and input from communities affected by HIV and AIDS. RWG recommend a set of priorities for HIV prevention funding to the CPG. The CPG reviews and approves these regional priorities and includes them in its statewide prevention Plan. The AIDS Administration uses the priorities in the Plan to design prevention programs, using the money available in each region via the formula.

The AIDS Administration is mindful of the burden of the HIV epidemic as it varies by jurisdiction *within* a region. For example, in the Central region, in accordance with the epidemiologic data, Baltimore City receives the most resources to conduct HIV prevention programming; Baltimore County receives the next highest amount of resources; Anne Arundel County receives the third highest amount, and so on. Some programming is conducted most efficiently on a multi-jurisdictional basis, and having funding available on a regional rather than jurisdictional basis allows for flexibility and other efficiencies.

The regional allocation formula has the support of Maryland's CPG as a community-developed, data-driven tool for measuring and fairly distributing resources according to need.

APPENDIX C:
Performance Indicators

Indicators are not included. Please see updated indicators in the application.

APPENDIX D:
Background and Glossary of Prevention Interventions

Background:

In June of 2003, the Maryland CPG completed their 2004-2008 HIV Prevention Plan and submitted it to the CDC. However, in the Fall of 2003, the CDC issued a new guidance that requires CPGs to rank HIV positive persons as the number one priority population and to identify the other priority populations by relying heavily on epidemiology. The guidance also required CPGs to have one statewide plan instead of regional plans. For these reasons the CPG needed to revise their HIV Prevention Plan. Thus in the fall of 2003 the CPG considered the latest epidemiologic profile, and used it to create and adopt a single set of statewide prevention priority populations.

The next task for the CPG was to develop a list of interventions for the statewide priority populations. At the 2004 CPG Retreat, members began developing a list of interventions by combining the identified regional interventions into a statewide list of interventions for each priority population. In February 2005, the Maryland CPG met with State Health Department program managers to discuss the identified program interventions. CPG members and program managers split into risk population groups according to their expertise. The discussion content included identifying the most effective interventions for priority populations, a brief overview of funded prevention programs, and programs goals. In a time when HIV prevention funding is being reduced every year, it was important to both program managers and CPG members to focus on the most effective interventions for risk populations in reducing the spread of HIV.

The following content is a glossary of CDC interventions and the interventions for each of the priority populations ranked in the Maryland CPG HIV Prevention Plan.

Glossary of CDC HIV Prevention Interventions:

Capacity Building: Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.

Community-level intervention (CLI): An intervention that seeks to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening only with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Group-level interventions (GLI): Health education and risk-reduction counseling that shifts the delivery service from the individual to groups of varying sizes. Group-level interventions use peer and non-peer models involving a range of skills, information, education, and support.

Health communications/public information (HC/PI): The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences. The messages are designed to build general support for safe behavior, support personal risk-reduction efforts, and inform people at risk for infection about how to get specific services. Channels of delivery include electronic media, hotlines, clearinghouses, and presentations/lectures.

Individual-level interventions (ILI): Health education and risk-reduction counseling provided for one individual at a time. ILIs help clients make plans for behavior change and ongoing appraisals of their own behavior and include skills-building activities. These interventions also facilitate linkages to services in both clinic and community settings (for example, substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and help clients make plans to obtain these services.

Intervention: A specific activity (or set of related activities) intended to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals and populations to reduce their health risk. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.

Partner counseling and referral services (PCRS): A systematic approach to notifying sex and needle-sharing partners of HIV infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, prevent transmission to others. PCRS helps partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Prevention case management (PCM): Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management, which provide intensive, ongoing, and individualized prevention counseling, support, and service brokerage.